# EXHIBIT 34

EDUCATIONAL COMMISSION for FOREIGN MEDICAL GRADUATES
3624 MARKET STREET, PHILADELPHIA, PENNSYLVANIA 19104-2685, U.S.A.
TELEPHONE: 215-823-2147 • FAX: 215-386-3185 • www.ecfmg.org

October 4, 2006

Artis Ellis
[redacted]

Dear Artis,

I was very sorry to hear that you needed surgery but hope all is well and wish you a quick recovery.

We are in receipt of your FMLA leave request and health care certification paperwork. The paperwork has been reviewed and your FMLA leave has been approved for the time period beginning September 29, 2006, and ending on approximately October 16, 2006. FMLA provides employees with up to twelve weeks of unpaid leave in a twelve-month period, and continuation of your health benefits under certain circumstances.

Any applicable available paid time off ("PTO") including sick time, vacation and optional holidays, must be utilized and will be counted as part of the twelve (12) week Family and Medical Leave time, unless STD benefits apply. The remainder of the leave shall be unpaid. Accruals for sick and vacation cease during an unpaid leave of absence.

**Short Term Disability (STD)**

I have enclosed a STD packet for both you and your physician to complete. If you are out of work for illness or injury beyond a two (2) week period and you are eligible for STD benefits, you will need to complete the enclosed Sun Life claim packet. If approved, this benefit will provide income during your absence. The first two (2) week period of your disability, as determined by the insurance company is know as the "waiting period" in which you will be required to use any available sick, vacation or optional holiday time. If your claim is approved, you will receive a disability benefit check directly from Sun Life. STD pays employees 60% of their annual salary. At the time your claim is approved, you will have the option of supplementing your disability payment with any available/remaining sick, vacation or optional holiday time. You can use your available time to cover the remaining 40% of your net pay until your time has been exhausted.

The Sun Life, STD claim packet is nine (9) pages in length. You are responsible for completing Section B (employee's statement) and your attending physician is responsible for completing Section C. Once complete, please return the packet to Human Resources. We will complete Section A and fax the final document to Sun Life for underwriting review.

E Ellis
EXHIBIT NO. 12
P. Antone, CRR

*ECFMG® is an organization committed to promoting excellence in international medical education.*

Returning to Work

As previously mentioned, your expected return to work date is October 16, 2006. I have enclosed a "Fitness for Duty" form that your physician will need to complete indicating that you are fit to return to your duties. Please return this form to Human Resources at least two days prior to your return. Please also remember that your manager will need to complete a "Personnel Change" form (when your leave ends) to accurately reflect your change in status.

If you have any questions regarding this letter or FMLA in general, please do not hesitate to contact me. I can be reached at 215-823-2147.

Sincerely,

JillAdrienne Purdy
Manager, Human Resources

Cc: Betty T. LeHew, HR Director
File

Encl: Fitness for Duty form
STD packet

ECFMG℠ EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES

3624 Market Street
Philadelphia PA 19104-2685 USA
215-823-2126 | 215-966-3124 Fax
www.ecfmg.org

VIA: US MAIL & Fed Ex # 8534 8007 7564

May 8, 2008

Artis Ellis
[redacted]

Dear Artis,

I was very sorry to hear that you/your husband will need surgery and wish you the best for a quick recovery.

Please be advised that your upcoming absence may fall under the parameters of the Family and Medical Leave Act of 1993 ("FMLA"). This act provides ECFMG employees with up to twelve weeks of unpaid leave in a rolling twelve-month period and continuation of you health benefits under certain circumstances. FMLA also ensures that your current position (or an equivalent job offering similar pay, benefits, etc.) will be available upon your ability to return to work.

In order for ECFMG to determine if your leave should be designated as FMLA and apply your rights under the leave, it is necessary for you to complete the enclosed Request for Family and Medical Leave and have your physician complete the Certification of Health Care Provider. You must furnish certification before the leave begins, or if that is not possible, within 15 days of our request for the certification. If you fail to do so, we may: (a) delay the commencement of your leave; or (b) withdraw any designation of FMLA leave, in which case your leave of absence would be unauthorized, which may subject you to disciplinary action up to and including termination. Please complete the employee portion and have your doctor complete the physician portion before returning them to me. I have also enclosed a Fitness for Duty form. When you are able to return to work, your physician will need to complete this document indicating that you are fit to return to your duties. Please return the Fitness for Duty form to Human Resources at least two days prior to your return to work. ***Please note: If in the next few weeks it is determined that only your husband needs surgery, then you would have his physician complete the Certification and return it back to us within 15 days.***

If ECFMG determines that your leave should be designated as FMLA, it will be unpaid unless you have available sick, vacation and/or optional holiday time or you qualify for Short Term Disability (STD) benefits. If you are out of work for illness or injury beyond a two (2) week period and you are eligible for STD benefits, you will need to complete the enclosed Sun Life claim packet. If approved, this benefit will provide income during your absence. The first two (2) week period of your disability, as determined by the insurance company is know as the "waiting period" in which you will be required to use any available sick, vacation or optional holiday time. If your claim is approved, you will receive a disability benefit check directly from Sun Life. STD pays employees 80% of their annual salary. At the time your claim is approved, you will have the option of supplementing your disability payment with any available/remaining sick, vacation or optional holiday time. You can use your available time to cover the remaining 20% of your net pay until your time has been exhausted.

The Sun Life, STD claim packet is nine (9) pages in length. You are responsible for completing Section B (employee's statement) and your attending physician is responsible for completing Section C. Once complete, please return the packet to Human Resources. We will complete Section A and fax the final document to Sun Life for underwriting review.

STD benefits are taxable under IRS regulations. Because the payment of this benefit is issued by the insurance company, not ECFMG payroll, we are not able to take the appropriate tax deduction from the disability benefit check that you receive from Sun Life. At the end of the year, you will be issued a 1099 tax form in which you will need to claim this additional income on your tax return.

There are several documents enclosed:

1. "Request for FMLA" form – Must be completed by the employee requesting a leave of absence (time off work) and submitted to Human Resources.
2. FMLA Healthcare Certification packet - Under the Federal guidelines, this information will be reviewed for approval and may hold your employment & benefits (with the same or equivalent position) and grant you the approved time off without penalty.
3. STD Request Form and Claim packet – Benefit claim for the insurance company that, if approved will help cover lost of income during the time you are out with an illness or injury.
4. "Fitness For Duty" form – Should you require surgery, your attending physician will need to complete this form indicating you are able to return to work and perform your duties. This form should be returned to Human Resources at least two (2) days prior to your return.

I realize that this is a great deal of information enclosed in one letter. Please call me if you have any questions regarding this letter, or FMLA leave in general. I can be reached at 215-823-2147.
Sincerely,

JillAdrienne Purdy
Manager, Human Resources

Cc: file;
B. LeHew, Director of Human Resources

Encl: FMLA Request form
FMLA Certification;
Fitness for Duty form;
Sun Life claim packet

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3624 Market Street
Philadelphia PA 19104-2685 USA
215-823-2126 | 215-966-3124 Fax
www.ecfmg.org

VIA: Regular & Certified Mail 7007 0220 0002 7822 6090

June 25, 2008

Artis Ellis
[redacted]

Dear Artis:

I am sorry to hear you are not well.

We are in receipt of your FMLA leave request. The paperwork has been reviewed and your unpaid leave has been approved for the time period beginning June 30, 2008 and ending August 1, 2008. FMLA provides employees with up to twelve weeks of unpaid leave in a twelve-month period, and continuation of you health benefits under certain circumstances.

Any applicable available paid time off ("PTO") including sick time, vacation and optional holidays, must be utilized and will be counted as part of the twelve (12) week Family and Medical Leave time, unless STD benefits apply. The remainder of the leave shall be unpaid. Employees have the option to use sick time (provided they have accrued the time) when the leave is not for their own serious health condition. You have chosen to accept that option. Accruals for sick and vacation cease during an unpaid leave of absence.

Your healthcare provider has indicated a recovery period of approximately 6 weeks, with a return to work date of August 4, 2008. You will be required to notify us (prior to your return to work) if your end of leave date changes. Please also remember that your manager will need to complete a Personnel Change Form when your leave begins and ends to accurately reflect your status. If you have any questions regarding this letter, or your FMLA leave, I can be reached at 215-823-2126.

Sincerely,

Joe Plush, HR Benefits Generalist
Cc: John Repasch

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Philadelphia PA 19104-2685 USA
215-823-2126 | 215-966-3124 Fax
www.ecfmg.org

VIA: Regular & Certified Mail 7007 0220 0002 7822 6106

July 7, 2008

Artis Ellis
3915 Oakside Drive
Houston, TX 77053

Dear Artis:

We are in receipt of your medical documentation stating that your surgery, originally scheduled for June 30, 2008, has been rescheduled for July 17, 2008. No additional documentation will be needed from you at this time as your FMLA leave will be approved for the time period beginning July 17, 2008. FMLA provides employees with up to twelve weeks of unpaid leave in a twelve-month period, and continuation of you health benefits under certain circumstances.

Any applicable available paid time off ("PTO") including sick time, vacation and optional holidays, must be utilized and will be counted as part of the twelve (12) week Family and Medical Leave time, unless STD benefits apply. The remainder of the leave shall be unpaid. Employees have the option to use sick time (provided they have accrued the time) when the leave is not for their own serious health condition. You have chosen to accept that option. Accruals for sick and vacation cease during an unpaid leave of absence.

Your healthcare provider has indicated a recovery period of approximately 6 weeks. You will be required to notify us (prior to your return to work) if your end of leave date changes. Please also remember that your manager will need to complete a Personnel Change Form when your leave begins and ends to accurately reflect your status. If you have any questions regarding this letter, or your FMLA leave, I can be reached at 215-823-2147.

Sincerely,

JillAdrienne Sampson, HR Manager
Cc: John Repasch

ECFMG HOUSTON

# ECFMG® Personnel Information Change Form

**All changes must be approved by the employee's manager. Check all that apply:**

- ☐ Rehire
- ☐ Promotion
- ☐ Primary Job Change (Title)
- ☐ Pay Rate Change
- ☐ Job Reclassification (Hierarchy Level)
- ☐ Job Description – Attach new JD
- ☐ Transfer to another department/state
- ☐ Additional Job
- ☐ Demotion
- ☐ FLSA Category – Exempt or Non-exempt
- ☐ Employee Type – regular FT, regular PT, % of regular PT, PTAN, or temporary
- X Employee Status – FMLA, personal leave, return to active, etc.
- ☐ *Layoff (no work available)
- ☐ *Resignation
- ☐ *Termination of Employment – Must be approved by HR prior to the action.
- ☐ Change or add to an Email distribution list

**Employee Name:** Artis Ellis

**Old Information:**

**New Information:**

**Full Explanation of Reason for Change: (Attach all related documents)**

Artis has been released by her physician to come back from FMLA approved leave.

**Effective Date:** 8/18/08 **(Required for all changes)**

**Termination Code:** **(Required for layoff, resignation & terminations)**

*** For Resignation and Termination, List all ECFMG property returned:** (Kronos, ID, key, phone, laptop, etc)

N/A

X _____ Date 8/19/08
Manager's Signature

X _____ Date 8/27/08
H.R. Director's Signature

X Betty Neto for Dr A Gobe Date 8/25/08
V.P. Signature

***For H.R. Use Only:***

☒ Terminations & Resignations: Send an email to Help Desk to discontinue email and voicemail access.

☒ Terminations & Resignations: Check that [illegible] has been returned.

**Entered By:** _____ Da[illegible]y: _____ **Date:** ____

ECFMG
EXHIBIT NO. 14
P. Antone, CRR

ECFMG® EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES
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RECEIVED
JAN 25 2012
ECFMG/HUMAN RESOURCES

# REQUEST FOR FMLA LEAVE OF ABSENCE

**Complete the form and return it to Human Resources.**

Name Artis Ellis Home Phone [redacted]

Street Address: [redacted]

City: [redacted] State: [redacted] Zip: [redacted]

Job Title Center Manager Dept & Ext. CSEC - Houston

I require a Leave of Absence due to the following reasons: (Check one)

___ Birth and care of my child or placement for Adoption/Foster Care of Child

Serious Health Condition that makes me unable to perform the essential functions of my job.

X Serious Health Condition affecting my ☐ spouse, ☐ child, ☐ parent, for which I need to provide care.

Please describe Assist with the care of my husband after Kidney transplant

I need this Leave of Absence to begin on 1/18/12 and I expect to return on or about 1/30/12.
Date Date

ECFMG HOUSTON

I realize that I will need to provide Medical Certification from my health care provider for reasons of my Serious Health Condition or that of a spouse, child or parent I will be caring for.

I understand that I will be informed in writing as to whether my request for Family Medical Leave of Absence has been approved. I will be required to utilize all available, applicable paid time off while I am out on this leave. I also understand that the FMLA leave can last no longer than twelve (12) weeks. Should I need time beyond the allotted FMLA leave, I will request a non-FMLA leave based on the ECFMG® policy.

Requestor's Signature Artis Ellis Date 1/18/12

Human Resources Signature [signature] Date 1/26/12

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Ellis
EXHIBIT NO. 18
P. Antone, CRR

Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

OMB Control Number: 1215-0181
Expires: 12/31/2011

**SECTION I: For Completion by the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: ECFMG - Sharon Trowell-Roman

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: Artis (First) . (Middle) Ellis (Last)

Name of family member for whom you will provide care: Kenneth (First) Ellis (Middle) (Last)

Relationship of family member to you: Husband

If family member is your son or daughter, date of birth: N/A

Describe care you will provide to your family member and estimate leave needed to provide care:
I'm requesting 2 wks LOA to care for my husband from having a kidney transplant
1/18/12 - 1/30/12

Artis Ellis
Employee Signature

1/18/12
Date



CONTINUED ON NEXT PAGE

**SECTION III: For Completion by the HEALTH CARE PROVIDER**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: Dr. Whitson Etheredge

Type of practice / Medical specialty: Nephrology

Telephone: (832) 355-3128 Fax: (832) 355-3664

**PART A: MEDICAL FACTS**

1. Approximate date condition commenced: 1/2/12

Probable duration of condition: _____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

___No Yes X. If so, dates of admission: 1/2/12

Date(s) you treated the patient for condition: 1/2/12

Was medication, other than over-the-counter medication, prescribed? ___No X Yes.

Will the patient need to have treatment visits at least twice per year due to the condition? ___No X Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

___No ___Yes. If so, state the nature of such treatments and expected duration of treatment:

_____

2. Is the medical condition pregnancy? X No ___Yes. If so, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

S/P Kidney Transplant 1/2/10

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care.

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No X Yes.

Estimate the beginning and ending dates for the period of incapacity: 1/2/12

During this time, will the patient need care? ___No X Yes.

Explain the care needed by the patient and why such care is medically necessary:

He will have frequent medical follow up in the clinic weekly for 1 month, then Bi weekly for 1 month then monthly for 4 years Unable to do any heavy lifting for 6 weeks.

5. Will the patient require follow-up treatments, including any time for recovery? ___No X Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Weekly visits starting 1/12/12 (based on findings/ complications) visits may increase

Explain the care needed by the patient, and why such care is medically necessary: Assistance with ADL's transportation to + from appointments he is not able to drive or lift anything greater than 5lbs

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?

___No X Yes.

Estimate the hours the patient needs care on an intermittent basis, if any:

8 hour(s) per day; 7 days per week from 1/12/12 through 3/15/12

Explain the care needed by the patient, and why such care is medically necessary:

Assistance with ADL's transportation to + from weekly clinic visits Assistance with meal preparation

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ___No ✓ Yes.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):
Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ___ day(s) per episode

Does the patient need care during these flare-ups? ___No ✓ Yes.

Explain the care needed by the patient, and why such care is medically necessary: Pt may need to have hospital admission if there are complications kidney transplant like episodes of rejection or infection it is not possible to estimate how many times this may occur or the duration of required treatment sbeeph

ADDITIONAL INFORMATION. IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER

Signature of Health Care Provider

1/9/12
Date

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210.

**DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

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3624 Market Street
Philadelphia PA 19104-2685 USA
215-386-5900 | 215-966-3124 Fax
www.ecfmg.org

# REQUEST FOR FMLA LEAVE OF ABSENCE

**Complete the form and return it to Human Resources.**

Name Artis Ellis Home Phone [redacted]

Street Address: [redacted]

City: [redacted] State: [redacted] Zip: [redacted]

Job Title Center Manager Dept & Ext. CSEC- Houston

I require a Leave of Absence due to the following reasons: (Check one)

___ Birth and care of my child or placement for Adoption/Foster Care of Child

___ Serious Health Condition that makes me unable to perform the essential functions of my job.

X Serious Health Condition affecting my ☐ spouse, ☐ child, ☐ parent, for which I need to provide care.

Please describe Assist with the care of my husband after Kidney transplant

I need this Leave of Absence to begin on 1/18/12 and I expect to return on or about 1/30/12.
Date Date

I realize that I will need to provide Medical Certification from my health care provider for reasons of my Serious Health Condition or that of a spouse, child or parent I will be caring for.

I understand that I will be informed in writing as to whether my request for Family Medical Leave of Absence has been approved. I will be required to utilize all available, applicable paid time off while I am out on this leave. I also understand that the FMLA leave can last no longer than twelve (12) weeks. Should I need time beyond the allotted FMLA leave, I will request a non-FMLA leave based on the ECFMG® policy.

Requestor's Signature Artis Ellis Date 1/18/12

Human Resources Signature [signature] Date 1/17/12

Recd 1/17/12 EW

ECFMG® is an organization committed to promoting excellence in international medical education.

01/14/2012 11:51AM (GMT-05:00)

Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

OMB Control Number: 1215-0181
Expires: 12/31/2011

**SECTION I: For Completion by the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: ECFMG - Sharon Trowell-Roman

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: Artis (First) Ellis (Middle) (Last)

Name of family member for whom you will provide care: Kenneth (First) Ellis (Middle) (Last)

Relationship of family member to you: Husband

If family member is your son or daughter, date of birth: N/A

Describe care you will provide to your family member and estimate leave needed to provide care:

I'm requesting 2 wks LOA to care for my husband from having a kidney transplant 1/19/12 - 1/30/12

Artis Ellis — Employee Signature

1/18/12 — Date



CONTINUED ON NEXT PAGE

**SECTION II: To be Completed by the Attorney/Health Care Provider**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: Dr. Whitson Ethridge

Type of practice / Medical specialty: Nephrology

Telephone: (832) 355-3128 Fax: (832) 355-3664

**PART A: MEDICAL FACTS**

1. Approximate date condition commenced: 4/2/12

Probable duration of condition: _____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

___No Yes X. If so, dates of admission: 4/2/12

Date(s) you treated the patient for condition: 4/2/12

Was medication, other than over-the-counter medication, prescribed? ___No X Yes.

Will the patient need to have treatment visits at least twice per year due to the condition? ___No X Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

___No ___Yes. If so, state the nature of such treatments and expected duration of treatment:

_____

2. Is the medical condition pregnancy? X No ___Yes. If so, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

S/p Kidney Transplant 4/2/12

[redacted]

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No X Yes.

Estimate the beginning and ending dates for the period of incapacity: 1/2/12

During this time, will the patient need care? ___No X Yes.

Explain the care needed by the patient and why such care is medically necessary:
He will have frequent medical follow up in the clinic weekly for 1 month, then Bi weekly for 1 month then monthly for 4 years unable to do any heavy lifting for 6 weeks.

5. Will the patient require follow-up treatments, including any time for recovery? ___No X Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:
Weekly visits starting 1/2/12 (based on findings/ complications) visits may increase.

Explain the care needed by the patient, and why such care is medically necessary: Assistance with ADL's transportation to + from appointments he is not able to drive or lift anything greater than 5lbs

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?

___No X Yes.

Estimate the hours the patient needs care on an intermittent basis, if any:
8 hour(s) per day; [redacted] days per week from 1/12/12 through 3/15/12

Explain the care needed by the patient, and why such care is medically necessary:
Assistance with ADL's transportation to + from weekly clinic visits
Assistance with meal preparation



CONTINUED ON NEXT PAGE

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ___No ✓ Yes.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):
Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ___ day(s) per episode

Does the patient need care during these flare-ups? ___No ✓ Yes.

Explain the care needed by the patient, and why such care is medically necessary: Pt may need to have hospital admission if there are complications with transplant like episodes of rejection or infection it is not possible to estimate how many times this may occur or the duration of required treatment-Becerra

ADDITIONAL INFORMATION, IF ANY, CONCERNING TREATMENT OR ADDITIONAL LEAVE NEEDED:

1/9/12
Signature of Health Care Provider Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210.

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

Form WH-380-FRevised January 2009

Notice of Eligibility and Rights & Responsibilities
(Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

OMB Control Number: 1235-0003
Expires : 2/28/2015

In general, to be eligible an employee must have worked for an employer for at least 12 months, have worked at least 1,250 hours in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form by employers is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. § 825.300(b), which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 29 C.F.R. § 825.300(b); (c).

[Part A – NOTICE OF ELIGIBILITY]

TO: Artis Ellis
Employee

FROM: Sharon Trowell-Roman, HR Manager
Employer Representative

DATE: September 5, 2012

On September 5, 2012, you informed us that you needed leave beginning on TBD for:

____ The birth of a child, or placement of a child with you for adoption or foster care;
__✓__ Your own serious health condition;
____ Because you are needed to care for your ____ spouse; _____child; _____ parent due to his/her serious health condition.
____ Because of a qualifying exigency arising out of the fact that your ____ spouse; _____son or daughter; _____parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.
____ Because you are the ____ spouse; _____son or daughter; _____ parent; _____ next of kin of a covered servicemember with a serious injury or illness.

This Notice is to inform you that you:

__✓__ Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)
____ Are not eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons):
____ You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately ____ months towards this requirement.
____ You have not met the FMLA's 1,250-hours-worked requirement.
____ You do not work and/or report to a site with 50 or more employees within 75-miles.

If you have any questions, contact Sharon Trowell-Roman, HR Manager or view the FMLA poster located in: See attached.

[PART B-RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE]

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by:** September 20, 2012 (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

____ Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request ____is/____ is not enclosed.
____ Sufficient documentation to establish the required relationship between you and your family member.
____ Other information needed: _____

__✓__ No additional information requested

CONTINUED ON NEXT PAGE



Form WH-381 Revised January 2009

If your leave does qualify as FMLA leave you will have the following responsibilities while on FMLA leave (only checked blanks apply):

____ Contact _____ at _____ to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day (or, indicate longer period, if applicable) grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.

__✓__ You will be required to use your available paid _____ sick, _____ vacation, and/or _____ other leave during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement.

____ Due to your status within the company, you are considered a "key employee" as defined in the FMLA. As a "key employee," restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. We ___have/____ have not determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us.

__✓__ While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every Every 6 months or when there is a significant change to the certification form. (Indicate interval of periodic reports, as appropriate for the particular leave situation).

**If the circumstances of your leave change, and you are able to return to work earlier than the date indicated on the reverse side of this form, you will be required to notify us at least two workdays prior to the date you intend to report for work.**

**If your leave does qualify as FMLA leave you will have the following rights while on FMLA leave:**

- You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as:
  - ____ the calendar year (January – December).
  - ____ a fixed leave year based on _____.
  - __✓__ the 12-month period measured forward from the date of your first FMLA leave usage.
  - ____ a "rolling" 12-month period measured backward from the date of any FMLA leave usage.
- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered servicemember with a serious injury or illness. This single 12-month period commenced on _____.
- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)
- If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.
- If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA leave entitlement, you have the right to have ____sick, ____vacation, and/or ___ other leave run concurrently with your unpaid leave entitlement, provided you meet any applicable requirements of the leave policy. Applicable conditions related to the substitution of paid leave are referenced or set forth below. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.

____For a copy of conditions applicable to sick/vacation/other leave usage please refer to _____ available at: _____.

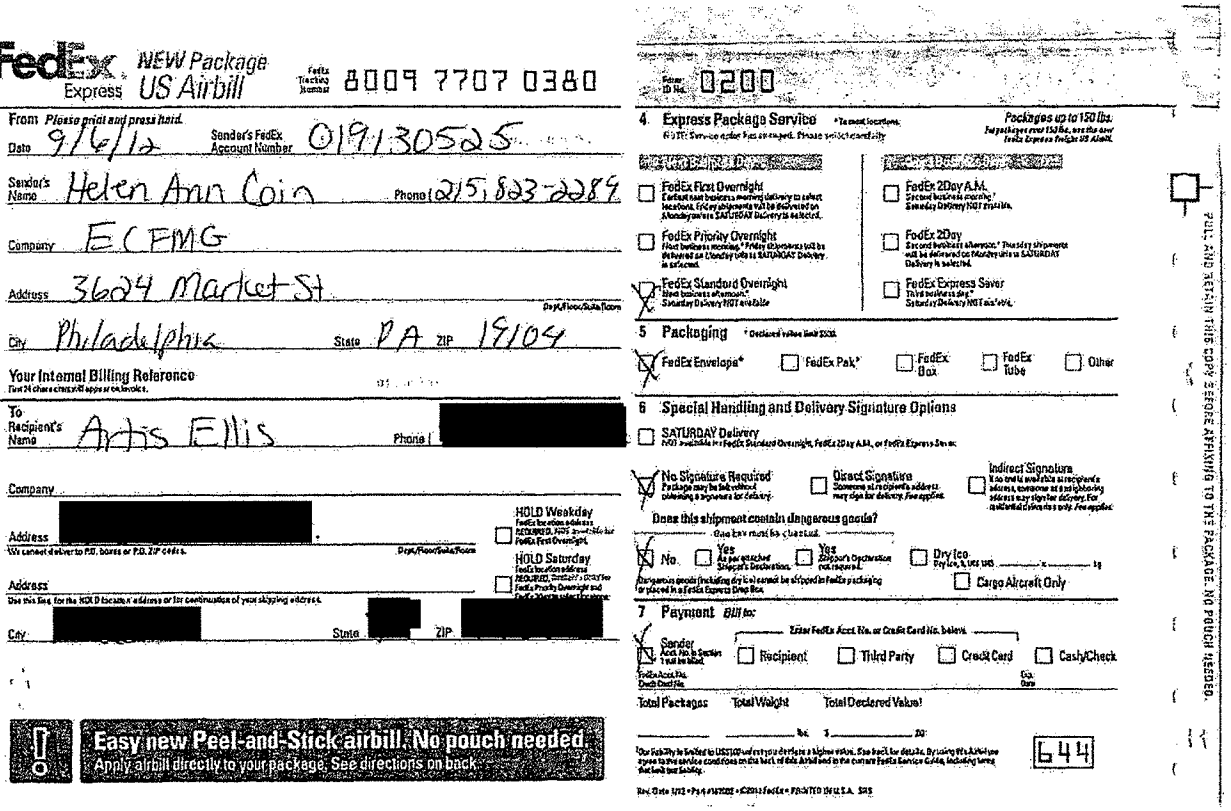
____Applicable conditions for use of paid leave: _____

**Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have any questions, please do not hesitate to contact: Sharon Trowell-Roman, HR Manager at 215-823-2147.**

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

It is mandatory for employers to provide employees with notice of their eligibility for FMLA protection and their rights and responsibilities. 29 U.S.C. § 2617; 29 C.F.R. § 825.300(b), (c). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

Form WH-381 Revised January 2009



FedEx Express NEW Package US Airbill

FedEx Tracking Number 8009 7707 0380

Form ID No. 0200

1 From Please print and press hard.

Date 9/6/12 Sender's FedEx Account Number 0191305525

Sender's Name Helen Ann Coin Phone (215) 823-2289

Company ECFMG

Address 3624 Market St Dept./Floor/Suite/Room

City Philadelphia State PA ZIP 19104

2 Your Internal Billing Reference
First 24 characters will appear on invoice.

3 To

Recipient's Name Artis Ellis Phone [redacted]

Company

Address [redacted] Dept./Floor/Suite/Room
We cannot deliver to P.O. boxes or P.O. ZIP codes.

HOLD Weekday
FedEx location address REQUIRED. Not available for FedEx First Overnight.

HOLD Saturday
FedEx location address REQUIRED. Available for FedEx First Overnight, FedEx Priority Overnight and FedEx 2Day only.

Address
Use this line for the HOLD location address or for continuation of your shipping address.

City [redacted] State [redacted] ZIP [redacted]

Easy new Peel-and-Stick airbill. No pouch needed.
Apply airbill directly to your package. See directions on back.

4 Express Package Service * To most locations.
NOTE: Service order has changed. Please select carefully.

Packages up to 150 lbs.
For packages over 150 lbs., use the new FedEx Express Freight US Airbill.

Next Business Day

- [ ] FedEx First Overnight — Earliest next business morning delivery to select locations. Friday shipments will be delivered on Monday unless SATURDAY Delivery is selected.
- [ ] FedEx Priority Overnight — Next business morning.* Friday shipments will be delivered on Monday unless SATURDAY Delivery is selected.
- [x] FedEx Standard Overnight — Next business afternoon.* Saturday Delivery NOT available

Second Business Day

- [ ] FedEx 2Day A.M. — Second business morning.* Saturday Delivery NOT available.
- [ ] FedEx 2Day — Second business afternoon.* Thursday shipments will be delivered on Monday unless SATURDAY Delivery is selected.
- [ ] FedEx Express Saver — Third business day.* Saturday Delivery NOT available.

5 Packaging * Declared value limit $500.

- [x] FedEx Envelope*
- [ ] FedEx Pak*
- [ ] FedEx Box
- [ ] FedEx Tube
- [ ] Other

6 Special Handling and Delivery Signature Options

SATURDAY Delivery
NOT available for FedEx Standard Overnight, FedEx 2Day A.M., or FedEx Express Saver.

- [x] No Signature Required — Package may be left without obtaining a signature for delivery.
- [ ] Direct Signature — Someone at recipient's address may sign for delivery. Fee applies.
- [ ] Indirect Signature — If no one is available at recipient's address, someone at a neighboring address may sign for delivery. For residential deliveries only. Fee applies.

Does this shipment contain dangerous goods?
One box must be checked.

- [x] No
- [ ] Yes — As per attached Shipper's Declaration
- [ ] Yes — Shipper's Declaration not required
- [ ] Dry Ice — Dry Ice, 9, UN 1845 ____ x ____ kg

Dangerous goods (including dry ice) cannot be shipped in FedEx packaging or placed in a FedEx Express Drop Box.

- [ ] Cargo Aircraft Only

7 Payment Bill to:

Enter FedEx Acct. No. or Credit Card No. below.

- [x] Sender — Acct. No. in Section 1 will be billed
- [ ] Recipient
- [ ] Third Party
- [ ] Credit Card
- [ ] Cash/Check

FedEx Acct. No. / Credit Card No. / Exp. Date

Total Packages / Total Weight / Total Declared Value†

____ ____ lbs. $ ____ .00

†Our liability is limited to US$100 unless you declare a higher value. See back for details. By using this Airbill you agree to the service conditions on the back of this Airbill and in the current FedEx Service Guide, including terms that limit our liability.

644

Rev. Date 3/12 • Part #150222 • ©2011 FedEx • PRINTED IN U.S.A. SRS

PULL AND RETAIN THIS COPY BEFORE AFFIXING TO THE PACKAGE. NO POUCH NEEDED.

ECFMG | EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES

3624 Market Street
Philadelphia PA 19104-2685 USA
215-386-5900 | 215-966-3124 Fax
www.ecfmg.org

# REQUEST FOR FMLA LEAVE OF ABSENCE

**Complete the form and return it to Human Resources.**

Name Artis Ellis Department CSEC - Houston

Job Title Center Manager Phone Extension (281) 260-7400 x2226

I require a Leave of Absence due to the following reasons: (Check one)

___ Birth and care of my child or placement for Adoption/Foster Care of Child

X Serious Health Condition that makes me unable to perform the essential functions of my job.

___ Serious Health Condition affecting my ☐ spouse, ☐ child, ☐ parent, for which I need to provide care.

Please describe Major Tumor removed from the Brain

I need this Leave of Absence to begin on 9/12/12 (Date) and I expect to return on or about 10/22/12 (Date)

I realize that I will need to provide Medical Certification from my health care provider for reasons of my Serious Health Condition or that of a spouse, child or parent I will be caring for.

I understand that I will be informed in writing as to whether my request for Family Medical Leave of Absence has been approved. I will be required to utilize all available, applicable paid time off while I am out on this leave. I also understand that the FMLA leave can last no longer than twelve (12) weeks. Should I need time beyond the allotted FMLA leave, I will request a non-FMLA leave based on the ECFMG® policy.

Requestor's Signature Artis Ellis Date 10/2/12

Human Resources Signature Shawn Innell Date 10/3/2012

Ellis
EXHIBIT NO. 19
P. Antone, CRR

ECFMG® is an organization committed to [illegible] international medical education.

EDUCATIONAL COMMISSION for FOREIGN MEDICAL GRADUATES
PHILADELPHIA OFFICE
3624 MARKET STREET, PHILADELPHIA, PENNSYLVANIA 19104-2685, U.S.A.
TELEPHONE: 215-386-5900 • FAX: 215-222-9983 • CABLE: EDCOUNCIL, PHA.

## REQUEST FOR SHORT TERM DISABILITY (STD)

**Complete the form and return it to Human Resources.**

Name Archis Ellis Department CSEC- Houston

Job Title Center Manager Phone Extension (281) 240-7400 X7226

ECFMG STD is a benefit that all regular full time employees are eligible for, after 90 days of employment, with an approved disability claim. STD benefits are paid out from Sun Life Assurance Company, not through ECFMG payroll. An STD claim packet must be completed by the employee and healthcare provider and returned to Human Resources for review/processing. An STD benefit claim approval is not guaranteed; the information provided must be reviewed and approved by the underwriting department at Sun Life Assurance Company. The benefit has a two (2) week-unpaid waiting period during which any available sick time, vacation time or optional holiday time must be used. After the two week waiting period, if the claim is approved, a benefit of 80% of the weekly salary will be paid as the benefit. All employees have the option of supplementing the STD benefit with any accrued/remaining sick, vacation or optional holiday time up to the full amount of the base net weekly pay until all available time is exhausted. Sun Life Assurance Company will provide written claim approval/denial for the employee.

I understand the above information regarding an ECFMG STD benefit claim and authorize the following choice for my STD benefit claim:

✓ I agree to have ECFMG supplement my 80% STD with any/all of the available benefit time indicated below for each pay period of my disability, until exhausted.

- [ ] Sick,
- [ ] Vacation and/or
- [ ] Optional Holiday time

____ I DO NOT wish to supplement my 80% STD claim with any available sick, vacation or optional holiday time. Any current time will remain available when I return from STD.

Employee's Signature Archis Ellis Date 10/2/12

Human Resources Signature Sharmell Lee Date 10/3/2012

*ECFMG is an organization committed to promoting excellence in international medical education.*

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 2/28/2015

**SECTION I: For Completion by the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: Artis Ellis

Employee's job title: Center Manager Regular work schedule: 7-3:30pm

Employee's essential job functions: _____

Check if job description is attached: X

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: Artis (First) _____ (Middle) Ellis (Last)

**SECTION III: For Completion by the HEALTH CARE PROVIDER**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address: Daniel Yoshor 1709 Dryden Houston Tx 77030

Type of practice / Medical specialty: Neurosurgery

Telephone: ( 713 ) 798 4696 Fax: ( 713 ) 798 3739

PART A: MEDICAL FACTS

1. Approximate date condition commenced: unknown

Probable duration of condition: unknown

Mark below as applicable:
Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
___No X Yes. If so, dates of admission:

9/12/12 St. Lukes Episcopal Hospital Houston TX 77030

Date(s) you treated the patient for condition:

9/14/12

Will the patient need to have treatment visits at least twice per year due to the condition? X No ___ Yes.

Was medication, other than over-the-counter medication, prescribed? X No ___ Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
X No ___ Yes. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? X No ___ Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: ___ No X Yes.

If so, identify the job functions the employee is unable to perform:

Need to stay off 4-6 weeks to recover from surgery

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

Patient underwent transsphenoidal resection of Pituitary macroadenoma on 9/14/12 - she would need 4-6 weeks to recover from surgery.

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No X Yes.

If so, estimate the beginning and ending dates for the period of incapacity: 9/12/12 – 10/22/12

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? X No ___Yes.

If so, are the treatments or the reduced number of hours of work medically necessary?
___No ___Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

_____

Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? X No ___Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups?
___ No ___Yes. If so, explain:

_____

_____

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency : _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

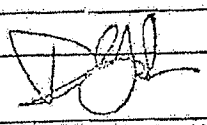
_____

_____

_____

_____

_____



Signature of Health Care Provider

Date 9/25/12

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 261f; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

# Designation Notice (Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

OMB Control Number: 1215-0181
Expires: 12/31/2011

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form by employers is optional, a fully completed Form H-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).

To: Artis Ellis

Date: October 2, 2012

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided.
We received your most recent information on October 2, 2012 and decided:

X Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.

**The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:**

X Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement: September 12, 2012 to October 22, 2012.

____ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

**Please be advised (check if applicable):**

____ You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.

X We are requiring you to substitute or use paid leave during your FMLA leave.

X You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position ____ is ____ is not attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

____ **Additional information is needed to determine if your FMLA leave request can be approved:**

____ The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than _____ (Provide at least seven calendar days) __, unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

(Specify information needed to make the certification complete and sufficient)

____ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

____ Your FMLA Leave request is Not Approved.

____ The FMLA does not apply to your leave request.

____ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617; 29 C.F.R. §§ 825.300(d), (e). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 – 30 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

Form WH-382 January 200